

Rybelsus (semaglutide)

Member and Medication Information (required)		
Member ID:	Member Name:	
DOB:	Weight:	
Medication Name/ Strength:	Dose:	
Directions for use:		
Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992		

Criteria for Approval *(All criteria must be met):*

- ☐ Adult with diagnosis of type 2 diabetes mellitus. Diagnosis code: _____ Chart Note Page #: _____
- ☐ Continued use of metformin at an appropriate or tolerable dose, unless contraindicated. (Note: For patients with GI intolerances to high dose generic metformin immediate release, the generic metformin extended release is also available.)
Medication(s): _____ Dates of therapy: _____ Chart Note Page #: _____
Details of Therapy/Failure: _____
- ☐ Trial and failure of or contraindication to a preferred SGLT-2 inhibitor
Medication(s): _____ Chart Note Page #: _____
Dates of therapy: _____ Details of Failure: _____
- ☐ Trial and failure of or contraindication to a preferred injectable GLP-1
Medication(s): _____ Chart Note Page #: _____
Dates of therapy: _____ Details of Failure: _____

Quantity Limits: *Maximum of 30 tablets per 30 days***Re-authorization Criteria:**

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Titration Dose per Package Insert:

3 mg tablet once daily for 30 days, then 7 mg tablet once daily for 30 days, may increase up to 14 mg tablet once daily

Initial Authorization: Up to two (2) months**Re-authorization:** Up to one (1) year**PROVIDER CERTIFICATION**

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature_____
Date